STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155414	A. BUILDING 00 B. WING	04/28/2011

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LINTON NURSING AND REHABILITATION CENTER	1501 A ST LINTON, IN47441

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F0000	This visit was for a Recertification and State Licensure survey. This visit included the Investigation of Complaint IN00089028. Complaint IN00089028- Substantiated. No deficiencies related to the allegations are cited. Survey dates: April 25, 26, 27 and 28, 2011 Facility number: 000333 Provider number: 155414 AIM number: 100288370 Survey team: Melinda Lewis, RN TC Sharon Whiteman, RN Marla Potts, RN Census bed type: SNF/NF: 32 Total: 32 Census payor type: Medicare: 7 Medicaid: 18 Other: 7 Total: 32	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 10 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on May 3, 2011 by Bev Faulkner, RN			
F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview and record review, the facility failed to ensure a restraint was used for the least amount of time possible, in that the facility did not have a reduction plan in place, for 1 of 1 residents	F0221	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 221 Restraints (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:Resident # 19 clinical record was reviewed to identify the medical symptoms resulting in the applied restraint. Occupational Therapy evaluation was completed to provide recommendations and follow	05/28/2011

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	reviewed with restraints in a sample of 10. Resident #19 Findings include On the initial tour, on 4/25/11 at 9:15 A.M., the Social Services Director indicated Resident #19 was confused and used a soft belt restraint. On 4/25/11 at 12:15 P.M., Resident # 19 was observed to be sitting in the dining room. Resident # 19 was observed to be in a		through with least restrictive measure and staff education. Education completed with therapy and nursing for documentation of release of restraint and resident's participation in transfer and walking programs. Education completed with all staff on need for resident to be free of restraint during meals and supervised activities. **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** Facility QI/QM will be ran to identify all residents with restraints in last 6 months. The interdisciplinary team will review residents and determine interventions selected are the best for residents maintaining highest level of functional and the least restrictive measure and that their plan of care reflects all of the above.. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** 1. Facility staff will be re-educated on identification of the medical symptoms that are warranted prior to restraint determination and selection. 2. Staff will be in-serviced on the documentation of alternative interventions prior to restraint application, initiation of pre-restraining assessment, physician orders identifying type of restraint, medical diagnosis,	

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	wheelchair with a soft belt restraint. On 4/25/11 at 1:30 P.M., Resident # 19 was observed to be propelling self about the facility. Resident # 19 was observed to be in a wheelchair with a soft belt restraint. On 4/26/11 at 9:40 A.M., Resident # 19 was observed to be observed to be sitting in her room. Resident # 19 was observed to be in a wheelchair with a soft belt restraint.		time frames for wearing the frequency of checking and removal. The plan of care will be updated as above with the initiation of the restraint and during the restraint elimination assessment. 3. Nursing staff will be in-serviced on necessary documentation of release of restraint at meals and other supervised activities.4. Residents with restraints will be discussed at regularly scheduled IPOC meetings, and at the quarterly, annual and/or significant change MDS. 5. Any resident with a restraint identified to have a change of condition will be reported in the 24 hour report and discussed in morning meeting. Interdisciplinary team members will review identified residents at care plan meetings. **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** Responsible party for this Plan of Correction includes the DNS/NHA who will do a facility walk-thru to visually review the residents to identify any use of articles that might be viewed as a restraint and correlate this with the resident's plan of care. Then this will be monitored by the Regional Rehab Director when she completes quarterly system reviews which includes restraints. Any discrepancies identified will be immediately addressed and	

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	On 4/26/11 at 2:00 P.M., Resident # 19 was observed to be propelling self about the facility. Resident # 19 was observed to be in a wheelchair with a soft belt restraint. The clinical record for Resident # 19 was reviewed on 4/25/11 at 11:10 A.M. The record indicated Resident # 19 had diagnoses that included but were not limited to dementia and arthritis. The MDS [Minimum Data Set]		reported to the NHA. Report of these findings will be presented to the next Risk Management/QA Meeting to assure compliance is maintained. **(e) Date of compliance: 5-28-11**	

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	assessment, dated 3/19/11, indicated Resident # 19 had severe cognitive impairment, and required extensive assistance of one with bed mobility, transfers, ambulation and toilet use. Resident # 19 utilized a trunk restraint daily. A Care plan, dated 2/24/11, indicated a problem of "Resident requires physical restraint to protect her from harm. Restraint type: 3/16/11 lap belt on when up in w/c. Specific			

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	target behaviors: agitation, obsession with bodily functions, constant attempts to toilet self. Medical symptoms: dementia, poor safety awareness. Less restrictive or alternative non restraint approaches that have proven to be INEFFECTIVE: self-release seat belt, lap buddy." The approaches were "Monitor for and report to the physician the following restraint related issues: Development of or increase in			

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	behavior/mood problem, decreased mobility, development of contractures, development of skin problems, development of or increased incontinence, increased risk for falls/injuries. Educate resident/responsible party of the following risks associated with use of above device: behavior/mood problems, contractures, decreased mobility. incontinence, ADL [activities of daily living] decline, skin			

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	breakdown, falls/injury. Screen for appropriateness of the device PRN [as needed] PT [physical therapy], OT [occupational therapy]. Restraint per physicians order: Type: Lap belt. Parameters for use: when up in w/c D/T [due to] safety issues. Frequency of checking and removing restraint: check Q [every] 30 min and release Q 2 hrs. with activity. Invite, encourage, remind, escort to activity programs consistent with residents interests.			

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	Provide safe environment, call light and personal items within reach, bed in low position. Physical restraint elimination assessment quarterly and PRN. Obtain physical restraint informed consent from resident responsible party." The Nurses Notes, dated 3/13/11 no time, indicated "...Self releasing alarmed belt which resident will unbuckle et [and] rebuckle. Poor safety awareness...."			

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	The Nurses Notes, dated 3/14/11 at 9:00 A.M., indicated "Late entry for 3-13-11 at 10:00 P.M. Res [resident] had lap buddy placed on w/c, res took lap buddy off x [times] 2. 15 min checks cont [continues]." The Nurses Notes, dated 3/15/11 at 2:00 P.M., indicated "This shift, dayshift, res found in room once and in BR [bathroom] once with lap buddy off. 15 min checks cont. Explained to res importance of			

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	leaving lap buddy on D/T [due to] safety." The Nurses Notes, dated 3/15/11 at 6:00 P.M., indicated "Resident found x 2 removing lap buddy in restroom. Found x 1 by OT removing lap buddy also. While this nurse was serving dinner trays I noted lap buddy not on and she stated she had taken it off and left it on her bed. Lap buddy replaced." The Nurses Notes, dated 3/16/11 at 12:15 P.M.,			

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	indicated "Res attempted to toilet self staff noted et questioned if res needed help res stated no et propelled w/c down hallway. Shortly after res noted in different bathroom with lap buddy off. Resident toileted." The Nurses Notes, dated 3/16/11 at 3:00 P.M., indicated "Res has attempted to transfer self x 5. Is toileted q 2 hours and prn. Therapy aware. Faxed MD for order for belt restraint as all options have been unsucessfull (sic).			

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	Awaiting response." The Nurses Notes, dated 3/16/11 at 5:00 P.M., indicated "Contacted Dr (name) and received order for lap restraint while up in w/c d/t [due to] other non restraint approaches not being effective..." A physician order, dated 3/16/11, indicated "May use lap restraint." A Pre-restraining Assessment, dated 3/16/11, indicated "...Interdisciplinary			

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	Team Evaluation- Date 3/16/11. Recommendations: lap restraint when up in w/c per OT...Alternatives to restraints (include length of time to be tried) have tried lap buddy since 2/24/11. Res removed continuously, not safe..Already on OT caseload. PT screened on 2-23-11 and recommended lap buddy as a trial." A Physical Restraint Elimination Assessment, dated 3/19/11, indicated "...Res to have soft lap			

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	belt D/T [due to] poor safety awareness D/T dementia. Gets up unassisted frequently to toilet self. High fall risk." In an interview with the Director of Nursing, on 4/26/11 at 1:30 P.M., she indicated Resident # 19 had fallen and the soft lap belt was to keep her from further falls. In an interview with the Rehab Director, on 4/27/11 at 11:00 A.M., she indicated she was going to provide an			

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	inservice to the staff on the need to remove the soft belt restraint during supervision. She indicated the staff would be educated to release the restraint during activities and meal times. 3.1-3(w)			

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F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, record review, and interview, the facility failed to follow physician's order for oxygen to be supplied to 1 of 2 resident's reviewed for oxygen in a sample of 10. (Resident #12) Findings Include: On 04/25/11 at 10:10 a.m., Resident #12 was observed seated in her wheelchair in the hall with oxygen tubing in her nostrils. The resident was observed to be hooked up to an oxygen tank which was not turned on. The resident did not appear to be in distress. On 04/25/11 at 10:13 a.m., RN #1 was observed to propel the resident up the hall and told the resident,	F0328	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 328 A) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: RN#1 had teachable moment presented by the Director of Nursing Services with a focus on "Guidelines for Administrating Medications" which included standards for oxygen use and orders. **B) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** Audit was conducted of current residents receiving oxygen. No negative outcomes were identified to	05/28/2011

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	"You need a tank." On 04/25/11 at 11:55 a.m., and 12:55 p.m., Resident #12 was observed seated in her room in a recliner chair. The resident was observed to have oxygen tubing in her nostrils and the tubing was attached to a condenser, which was set on 2 liters. On 04/26/11 at 9:30 a.m. and 9:55 a.m., Resident #12 was observed seated in her room in a recliner with oxygen tubing in her nostrils. The oxygen was set at 2 liters. Review of Resident #12's clinical record on 04/25/11 at 11:00 a.m., indicated the following: Resident #12 had diagnoses which included, but were not limited to, Organic Brain Syndrome, Alzheimer Disease, congestive heart failure, Pneumonia, Renal Insufficiency, low oxygen saturation, chronic renal failure.		those residents identified. **C) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Licensed nurses were re-educated on: Standard and Guidelines for Drug Administration - with specific focus on oxygen use and orders. **D) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** DNS/Designee will do a weekly random review of oxygen for the next four weeks then twice a month X 2 months to include all shifts and weekends to identify any oxygen not being administered per facility standards. Any issues identified will be immediately corrected and reported to the NHA. The above audits will be reviewed at the next Risk Management/QA committee meeting to determine if compliance has been met and recommended that monitoring will be quarterly by the RDCO when she completes her system reviews which includes physician orders (including orders for oxygen). **E) Date of compliance:** 5-28-11	

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	155414	A. BUILDING 00 B. WING	04/28/2011

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A physician's telephone order, dated 04/05/11 at 4:00 p.m., indicated, "Continuous O2 (oxygen) given per (nasal cannula) @ 2 (liters).

A physician's telephone order, dated 04/14/11 at 3:00 p.m., indicated, "...Send (Resident #12) to (local hospital emergency room)...."

A "Daily Skilled Nurses Notes," dated 04/14/11 at 2:00 p.m., indicated, "(Resident #12) fainted. CNA lower (sic) resident to floor... (Vital signs) (temperature) 97.7, (blood pressure) 140/96, (oxygen saturation) 96%, (heart rate) 86, (respiratory rate) 18.

A "Daily Skilled Nurse's Note," dated 04/14/11 at 2:10 p.m., indicated"(Physician) notified... (Resident #12) unable to stand and lethargic. (Physician) order obtained to watch for 1 (hour) if no better send to (Emergency Room)."

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A "Daily Skilled Nurse's Note," dated 04/14/11 at 3:15 p.m., indicated, "(Local ambulance company) will transport to (Emergency Room)...."

A "Hospital/Acute Care Transfer" sheet, dated 04/14/11, indicated Resident #12 was transferred to the local hospital. The transfer sheet indicated Resident #12 fainted while being transferred by a CNA. The transfer sheet indicated the resident's oxygen saturation was 75-76 %.

A Physical Therapy Progress Note, dated 04/14/11, indicated Resident #12 did not receive physical therapy on this date due to hospitalization due to labored breathing, lethargy, confusion, and oxygen saturation of 72-73%.

A "Nursing Admission Assessment," dated 04/23/11, indicated Resident #12 returned to the facility from the local hospital

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	on this day. The admission assessment indicated Resident #12 was to receive 3 liters of oxygen via nasal cannula. Clinical record review lacked documentation supporting an order for oxygen at 3 liters via nasal cannula. The DON (Director of Nursing) was interviewed on 04/25/11 at 1:10 p.m., regarding Resident #12's oxygen order since re-admission from the hospital. The DON indicated she would call the physician for order clarification. Clinical record review on 04/26/11 at 10:00 a.m., indicated a physician's telephone order with "4/23/11" written under the "Date Ordered" column. The physician's telephone order indicated, "Clarification written 4/25/11 - Clarification: O2 (oxygen) @ 3 (liters) via nasal cannula @ all (times)."			

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	3.1-47(a)(6)			
F0465 SS=D	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to insure kitchen equipment was clean and without greasy/dust residue. These observations were made during 1 of 2 kitchen observations. Findings Include: During initial observation tour of the kitchen on 04/25/11 at 9:15 a.m., with the Dietary Manager present the following observations were made: The dish washing machine was observed to be soiled with dust/grease buildup on top of the machine and on the piping underneath the machine. The rack which held the sanitization buckets was soiled with	F0465	The facility must provide a safe, functional, sanitary and comfortable environment for resident, staff and public. **(A)What corrective action(s) will be accomplished for those residents found to have been affected:** The dust and grease build up noted on the dish machine and on the piping underneath the machine was cleaned and sanitized on 4/25/11. The rack containing the sanitization buckets was cleaned and sanitized on 4/25/11. The grease/dust noted on the back and top of the juice machine was cleaned and sanitized on 4/25/11. **(B)How will you identify other residents having potential to be affected and what corrective action will be taken:** Residents receiving breakfast meals on 4/25/11 were potentially affected; though, no specific resident was identified. **(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:** Food and Nutritional Service Department has been educated to the components of F 371 with a focus on sanitary conditions to	05/28/2011

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	black/greasy matter. The back and top of the juice machine was soiled with a heavy layer of grease/dust buildup. Interview of the Dietary Manager on 04/25/11 at 9:20 a.m., indicated the equipment should have been cleaned over the weekend. 3.1-19(f)		include the items noted under section A. Review of the QIS Kitchen Inspection Tool was reviewed and will be used monthly as part of this educational process. **(D)How the corrective action(s) will be monitored to ensure the practice will not recur:** The Consultant Dietitian, Food Service Manager and/or designee will conduct a weekly sanitation audit for a minimum of three times per week for four weeks, then monthly X 2 months. The audit will include items noted in section A. The findings/results of these audits will be reported to the Risk Management/QA committee to determine if substantial compliance has been achieved and quarterly monitoring for oversight by the RD when they complete they Quarterly reviews is recommended. **(E) Date Certain:** 5-28-11	
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure a resident using oxygen in the facility had a current order	F0514	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts	05/28/2011

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	for the oxygen, for 1 of 2 residents reviewed with oxygen orders, in the sample of 10. Resident #100 Findings include: 1. Resident #100's clinical record was reviewed on 4/25/11 at 1:00 P.M. The resident returned from the hospital on 3/30/11 and readmission orders did not include an order for oxygen. The admission Minimum Data Set (MDS) assessment, dated 4/6/11, indicated the resident had an used oxygen in the past 14 days both at the facility and prior to facility stay. Nurses notes, dated 3/30 through 4/5/11, included documentation at least each shift, that the resident used oxygen at 3 liter per nasal annual. Nurses notes from 4/6/11 through 4/22/11 included at least a daily entry which indicated the resident used oxygen at 2 liters per nasal cannula. During interview with the Director of Nursing on 4/25/11 at 1:00 P.M., she indicated the resident had been admitted to the facility with oxygen and staff had just failed to write the order. She provided a hospital progress note, dated 3/29/11, of "oxygen decreased to nasal cannula 3 liters."		alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 514 Clinical Records (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: This information was taken from a closed record. Active licensed staff having cared for resident #100 from 3-30-11 to 4-5-11 were re-educated per teachable moment on the need for oxygen orders. . **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** . An audit was conducted of residents receiving oxygen for accurate orders no other residents were identified. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Nursing staff will be re-educated on obtaining orders for oxygen standards and guidelines, and professional standards of practices for maintaining clinical record documentation of assessments/orders upon return **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put**	

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	The MDS Coordinator provided an order on 4/26/11 at 1:00 P.M., which indicated "4/26/11 12:25 p.m., clarification order oxygen per nasal cannula 2 to 3 liters to maintain sat above 90% effective 3/30/11." 3.1-50(a)(1)		**into place:** DNS/Designee will do a weekly random review of oxygen for the next four weeks then twice a month X 2 months to include all shifts and weekends to identify any oxygen not being administered per facility standards. Any issues identified will be immediately corrected and reported to the NHA. The above audits will be reviewed at the next Risk Management/QA committee meeting to determine if compliance has been met and recommended that monitoring will be quarterly by the RDCO when she completes her system reviews which includes physician orders (including orders for oxygen). **(e) Date of compliance:** 5-28-11	